INDEX OF DOCUMENTS

LONG-TERM CARE SUPPORTS AND SERVICES
ADVISORY COMMISSION
APRIL 23, 2007

WORKGROUP A, MINORITY REPORT #2, LTC TASK FORCE

VISITING NURSES ASSOCIATION, ARTICLE ON MEDICAID MAKEOVER

LONG-TERM CARE SUPPORTS & SERVICES
ADVISORY COMMISSION
EXECUTIVE COMMITTEE
APRIL 2, 2007
MINUTES

ATTENDEES: Andy Farmers, RoAnne Chaney, Christine Chesny, Jon Reardon, Hollis Turnham, Jackie Tichnell, Gloria Lanum

Chaney provided a very favorable update on Commissioner Jim Francis-Bohr's medical condition. He should be released home this week.

DEBRIEFING OF LAST COMMISSION MEETING - Most considered the meeting had a positive outcome. It was suggested that the draft guidelines be consolidated into one document with page numbering and a table of contents. Tichnell volunteered to create this document. There was discussion regarding the formatting of the meetings (e.g., provide information one meeting with public input at the following meeting; or doing both in one meeting). The decision was to try staggering the meetings which means that each Commissioner needs to publicize the meetings and their contents to their constituencies.

Farmer will draft a template that will frame initial questions for the public. This will provide a focus to the discussion. It was suggested that consumers from the SPE pilot areas be encouraged to provide input to the Commission.

The public comment cards will be revised to include contact information, at the commentor's approval. Tichnell will revise these cards.

COMMISSION REVENUE LETTER - This letter was finalized and hand delivered to the legislature. Tichnell will send to the Commissioners with encouragement to submit letters to the editors of the major newspapers regarding the issue. Chesny will draft a template to use for the letters to the editor.

COMMISSION REPRESENTATION - Confusion was expressed regarding what population each Commissioner represented. There needs to be a focus discussion on this topic.

APRIL AGENDA -

- **SPE DEMONSTRATION STATUS REPORT:** Farmer will provide general questions regarding the SPE and Head will provide an SPE primer to the Commissioners
- **WORKGROUPS** - it was determined that Turnham would provide a written framework for expectations of each workgroup. Many issues still needed to be resolved: how many, for what purposes, for each Task Force Recommendation, open to the public, their charge, the connection to the Commission, how to get started? The workgroup decisions would be finished at the May meeting; Farmer would appoint chairs to each workgroup. Each Commissioner would be a part of at least one workgroup.
- **REVENUE COALITIONS ACTIVITY** - This needs to be added to the budget update and determine next advocacy steps.
- **FUTURE MEETING FORMAT AND LOCATIONS** - There was brief discussion regarding the possibility of changing the meeting times. It was determined that, for most of the Commissioners, the existing time was working well. There was also discussion regarding the need to change locations for these meetings with at least one meeting a year in Detroit. The Office would provide the logistics. Having out-state meetings would allow for maximum public input.

Governor Granholm Makes Appointments

LANSING - Governor Jennifer M. Granholm today announced the following recent appointments to the Michigan Long-Term Care Supports and Services Advisory Commission and the Michigan Board of Athletic Trainers:

Michigan Long-Term Care Supports and Services Advisory Commission

Sandra J. Kilde of Lansing, president and CEO of the Michigan Association of Homes and Services for the Aging. Ms. Kilde is appointed to represent primary or secondary consumers of long-term care supports and services for a term expiring December 31, 2009. She succeeds Linda Mulligan who has resigned.

Denise B. Rabidoux of Ann Arbor, president and CEO of Evangelical Homes of Michigan. Ms. Rabidoux is appointed to represent direct care staff providing long-term care supports and services for a term expiring December 31, 2008. She succeeds Sandra J. Kilde who has been appointed to represent another group within the commission.

The Michigan Long-Term Care Supports and Services Advisory Commission was established as an advisory body within the Michigan Department of Community Health and serves as a forum on for the discussion of issues relating to the provision of long-term care support and services in Michigan.

These appointments are not subject to disapproval by the Michigan Senate.

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MICHIGAN HOUSE OF REPRESENTATIVES

MARY VALENTINE

STATE REPRESENTATIVE

April 5,2007

Mr. Andrew Farmer
Michigan Long Term Care Supports & Services Advisory Commission
109 Michigan Avenue, 7th Floor
Lansing, MI 48933

Dear Mr. Fanner,

Thank you for writing me concerning the budget crisis Michigan is facing and the impact the Senate proposed cuts would have on long term care support services. I appreciate hearing from you and value your thoughts.

I clearly understand that Michigan's economic future is at risk if we do nothing except lower taxes and cut programs. For the past several years this has been the norm - with dismal results. I firmly believe that during this transition period we must invest in our people. Part of investing in our people includes coming to terms with the new realities of global competition and the importance of educating our citizens to be able to compete and maintain a high quality of life.

It is also important to look at ways in which the State can streamline the services it provides, while maintaining a high degree of quality. My colleagues and I are diligently working to develop a comprehensive plan to resolve the wide variety of challenges facing Michigan.

To that end, my vision is to ensure that all families thrive in a secure Michigan while taking bold steps to move Michigan forward.

Sincerely,

Mary Valentine

Mary Valentine
State Representative
91st District

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES
Update for the Long-Term Care Supports and Services Advisory Commission
April 23, 2007

1. Long-Term Care Connections (LTCC) Projects
   a. Quarterly reports on the progress of development are due from the sites at the end of April
   b. Sites are using Service Point for data entry and data collection.
   c. A LTC Connections Logic Model has been drafted as the result of a workgroup of staff, stakeholders, and consumers and this will drive the evaluation component conducted by the Michigan Public Health Institute

2. System Transformation Grant Project
   a. Draft Strategic Plan was submitted to CMS last week. Presentation to CMS officials on April 25, 2007.

3. Office Development
   a. Continue to work with MDCH Human Resources to develop and establish positions so that all Office positions may be recruited for and filled by the end of Summer. Current budget situation and freeze on personnel transactions will affect the ability to fill positions.
   b. Planning move to Capitol View Building.

4. Long-Term Care Insurance Partnership program
   a. Received notice from Robert Wood Johnson of $50,000 technical assistance grant award.

b. The first planning meeting to include state agency staff and stakeholders is anticipated for early May.
c. State plan amendment is due to CMS by the end of September.

5. MI Choice Waiver Renewal Stakeholder Forums
   a. These meetings are every two weeks; include ~ 40 stakeholders. Focused on informing stakeholder of MI Choice Waiver renewal issues and directions.
   b. State staff provided a power point presentation on the MI Choice waiver including its history, progress, reimbursement methodology, nursing facility transition success, and expenditures.
   c. A subgroup on waiver services in assisted living facilities is meeting as part of this work.

6. Prepaid LTC Health Plan pilot project
   a. The concept paper developed to overview this project is completed and has been reviewed by MDCH leadership.
   b. The concept paper will be refined and transmitted to CMS for discussion and guidance pending 1915 (b) & (c) waiver applications.
   c. The design of a feasibility study is nearly completed, and it is expected that work on the feasibility study will begin in May.

7. Deficit Reduction Act - Money Follows the Person grant
   a. Staff will soon convene a workgroup of stakeholders to develop the Operational Protocol required by CMS; due to CMS in May

b. The grant requirement of having a full-time Project Manager in place may need to be negotiated with CMS given the existing freeze on hiring.
c. Work continues on developing annual benchmarks for numbers of projected to transition under this project. This will frame our planned spending of the grant award.

8. Other
   a. We continue to work on the planning for our new office space, which will be in the Capitol View Building
   b. We are doing the initial planning for next year's budget and contracts for SPEs and other grant projects
   c. We are working on the expansion of Self-Determination in Long-Term Care efforts to the rest of the MIChoice Waiver program. This will involve training of the waiver sites over the summer.
   d. A consultation draft of a Person-Centered Planning Practice Guideline is being finalized and will be submitted to interested stakeholders for a 45-day review and comment period, by the beginning of May.

Presentation to the Long Term Care Commission
on Single Points of Entry Workgroup of the Long Term Care Task Force
By Susan Steinke
April 23, 2007

Process

- ✔ Built on a process started by Sarah Slocum when she was at AARP.
- ✔ Had two major reports and a follow-up meeting to review questions from the LTC Task Force.
- ✔ Had a two-day retreat that included Dann Milne, Ph. D., a national expert on Single Points of Entry.
- ✔ There were two minority reports.

Participants

The Workgroup included representatives of the Long Term Care Task Force, Area Agencies on Aging (AAA), DCH, DHS, AARP, the Alzheimer's Association, Elder Law of Michigan, non-AAA waiver agents, The Arc Michigan, Michigan County Medical Care Facilities Association, Michigan Home Health Association, Macomb County Senior Services, State Long Term Care Ombudsman's Office, Michigan Association of Homes and Services to the Aging, Health Care Association of Michigan, Developmental Disabilities Council, and OSA.

We also had special presentations from Sally Burton Hoyle and Sherry Fernandez on person-centered planning; Katherine Beck-Ei of Alzheimer's on persons with dementia and person-centered planning; and Dann Milne on SPE models around the nation. Members of the Workgroup provided information and expertise on other long term care delivery models around Michigan.

Simultaneous Translations

- ✔ Case Coordination/Supports Coordination/Care Planning
  - ✔ Every organization had a different term for this function, and some organizations have concerns with the use of the word care vs. supports. In the end, we went with "supports coordination" though you will see many of the documents have all three to keep people on the same page.
- ✔ Balancing of Long Term Care through Proactive Choice Counseling
  - ✔ This was formerly called "nursing home diversion". There was strong pushback from organizations who felt this was a negative way to term this function. We renamed it.

Other Fun with Words

We had some significant points of difference on what words to use to describe what functions. Some of these differences were perceived to be used to delay discussion and consensus building.

One perennial favorite debate was "screening vs. assessment". An offshoot of that debate was "universal assessment vs. comprehensive assessment".

Confusion

Periodically, there was confusion about the difference between the Independent Facilitator and the External Advocate.

Points of Contention

What we discovered early on (even before the Task Force started) was that any debate or discussion about SPE is heated, lively and capable of helping you discover every stressor or concern you have ever had with the long term care "system". More specifically, here are some of the questions/concerns:

- ✔ What exactly does it mean to not be a direct provider of services?
- ✔ Case management (supports coordination) is moving to the SPE?
- ✔ Who gets to be an SPE?
- ✔ Who gets to do the external advocacy role? Should it be random acts of advocacy or should it be a single agency that can do both individual and systemic advocacy?

Variations Between the Workgroup A Report; Final Report of the Task Force; Executive Order 2005-14 and PA 634 of 2006

First, and easiest, the Executive Order is very brief and vague on the topic of Single Points of Entry which allowed quite a bit of flexibility by DCH in design. It added a requirement of minimum geographic areas which needed to be covered. There are parts of the demonstration projects which differ significantly from the either of the reports and from PA 634.

The Executive Order also did not mention the recommendation for the external advocate. The Task Force Report recommended both expanding and fully funding an external advocate and PA 634 requires access to it. In the case of the Task Force Report and PA 634, the external advocacy function referred to is the one outlined in the Model Act contained in the TF Final Report.

The Final Report of the Task Force did a good job of further delineating the reports from Workgroup A, and there are no substantive differences.

PA 634 has its biggest points of difference in the rollout of SPEs. The Workgroup and the Task Force both recommended going statewide in 3 years. PA 634 limits the number of SPEs and has a sunset after 5 years.

Legislative progress of Single Point of Entry

A System For The Future

Starting points:

- The Michigan Medicaid Long Term Care Task Force, members endorsed the LTC final report.
- This Task Force represented providers, consumers, profit and non-profit nursing home organizations, home health, legislators, state department and consumer groups.
- They voted **unanimously** in support of SPEs in their Final Report.

Starting points:

- The Final Report was sent to the Governor and an Executive Order issued to set up the Office of Long Term Care Supports and Services and the Long Term Care Supports and Services Commission. DCH then initiated steps to set up the pilot programs.
- The Final Report included a model act to meet future needs for long term care outlined in very specific legislative terms. An executive order can be easily changed, legislation puts mandates into law and is harder to alter.
- Advocates associated with the task force approached Representative Shaffer to sponsor the legislation for the Single Point of Entry guidelines.

HB 5389

- The model act language was then submitted to the Legislative Services Bureau who worked with legislative staff and advocates to draft the bill language.
- This closely mirrored the model act taking into account legislation that already existed and defining legal terminology. It was introduced in the House in November 2005 and allotted as House Bill 5389.
- HB 5389 was assigned to the House Committee on Senior Health, Security, and Retirement

HB 5389

- As a part of the committee process a workgroup of a wide range of stakeholders met over several months to fine tune the bill.
- Language changes were made during the course of these meetings. They came from the stakeholders and where they were appropriate and agreed upon by consensus were included.
- The bill substitute was then reported out of the Senior Health, Security and Retirement Policy Committee

HB 5389 – stalled!

- The best laid plans……
- The substitute bill including all the amendments was reported out of committee in May and languished until September before the House passed it.
- It took until 14th December to get the bill through the Senate and back to the House for a final vote.
- The Governor officially signed the bill on December 31st 2006 and **PA 634** was born.

PA 634 differences

- Like “Topsy” once the bill got into the legislative process, committees and workgroups, it grew
- Went from 5 pages in the original bill to 14 in the final version during the legislative process.
- A lot of the input came from the stakeholders in the workgroup, and was required to clearly identify the intent and mandate of the bill.

PA 634 differences

- Expanded language included:
  - a wider more detailed description of data collection required by the legislature to support the need for a single point of entry.
  - Expanded language to clearly identify rights of consumer and responsibilities of SPE.

PA 634 differences

- Specific time frames for the completion of an evaluation and plan for consumers requiring long term care including as a result of an emergent medical necessity.
- Required the authority of the legislature before expanding the program from the 4 pilots to a state wide program.
- Added a sunset on the provisions of the bill until 12/31/2011.

Pilot programs under PA 634

- While the legislation was facing its difficulties in the two chambers, the pilot program RFP's had been issued and the pilot program sites awarded.
- The language in PA 634 specifically requests data that must be collected during the first two years that the pilots are in operation, which DCH must ensure.
- PA 634 also places into law the requirement that a single point of entry advocacy cannot be a provided of Medicaid funded services. There is NO way around this one as it is the law.

Pilot programs under PA 634

- the SPE process should be mandatory for individuals eligible for Medicaid funded programs to utilize the SPE program.

- individuals who are private pay should be able to access SPE agency services;

- information and referral/assistance should be available to everyone at no cost;

Pilot programs under PA 634 :

- long term care providers will be required to inform consumers about the availability of the SPE agency;
- Separation of Service Authorization & Provision
- an SPE should do service authorization;
- an SPE should NOT do direct service provision;

Pilot programs under PA 634

- The legislature will review the evidence based data as part of the 2008-2009 budget process; and recommend continuance of the program if they feel the data supports it.

HB 5389 Legislative Intent

- Ideally, HB 5389 provides legislative authority for a Single Point of Entry System that will provide information about the full array of options open to consumers in need of long term care opportunities including person-centered planning, and consumer choice.

- **The consumer trumps all!**

Legislative Intent

- PA 634 reflects the legislature's intention that:
- bias in functional and financial eligibility determination or assistance, and the promotion of specific services to the detriment of consumer choice does not occur.
- consumer assessments and support plans are completed in a timely, consistent, and quality manner through a person-centered planning process and that other required criteria are adhered to.

Legislative Intent

- that quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication;
- consumer access to an independent consumer advocate;
- that data and outcome measures are being collected and reported as required under the act and by contract;
- that consumers are able to choose their supports coordinator.

Why Legislation Now?

- This legislation conforms to the recommendations from the Michigan Medicaid Long Term Care Task Force.
- The task force was set up as a result of the Supreme Court agreement, in the "*Eager vs. Engler* (later *Granholm*) class action suit filed on the basis of the "Olmstead" agreement.
- It brings Michigan one step closer to parity of treatment for those with long-term care needs.

Why Legislation Now?

- This legislation provides legislative control over long term care services provided under Medicaid and supplied by the pilot programs;
- it provides a mechanism for the SPE pilots to act as a ‘triage’ point and ensure that consumers have options for care relevant to their level of health care needs.
- Eventually this legislation will plug into over-arching Long Term Care legislation and form the Long Term Care Code

Legislative progress of Single Point of Entry

Presented by:

Susan Martin

Chief of Staff

District 59

MI House of Representatives

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Michigan's Long Term Care Connections

Long Term Care Supports and Services Advisory Commission

April 23, 2007

Michael J. Head

Overview

1 Request For Proposal Process

2 Contracts

3 Start up Activities

4 Performance-Output Monthly Report Format

5 Early Data

6 Current Priorities of the four sites

1: Request for Proposals

- RFP issue date: November 14, 2005
- Proposals due: February 17, 2006
  - Reviewed by a 24-person team
  - Final determinations made by a 12 Joint Evaluation Committee

Award date: April 17, 2006*

Contract finalization: June 2006

Contracts initiated: July 1, 2006

Core Functions Required in the RFP

- Planning and Collaboration
- Outreach and Public Education and Advocacy
- Information and Assistance
- Facilitated Person-Centered Planning (with options for independent facilitation)
- Pro-Active Choice and Transition Services
- Long-Term Care Options Counseling
- Ongoing Supports Coordination
- Assure Consumer Rights and Responsibilities
- Quality Management and Improvement

Deliverables requested in the RFP

- SPE Initiation and Development
- Outreach and public education plan including health, risk and safety
- Information and Assistance including development of information materials and process development
- Options Counseling
- Proactive choice of benefits counseling to be offered through hospitals, nursing facilities and community agencies
- Function Eligibility for Medicaid—offer to administer
- Person Centered Planning Process
- Ongoing supports coordination—a protocol to have the supports coordinator broker services

Governor's Press Release

- $34.83 million for four demonstrations
  - Detroit, $13.1 million
  - Southwest Michigan, $7.18 million
  - Western Michigan, $9.15 million
  - Upper Peninsula, $5.4 million

  When fully operational will cover over 47% of state's population .

Current Budget Picture

- FY 2006: Start-up contracts total $2.4 M
- FY 2007: **$9.0 M appropriation**
  - Initial 1st year contracts: $13.5 M
  - Spending projected to be close to $9.0 M
- FY 2008 Proposed: $14.7 M appropriation
  - Initial 2nd year plan: $18.8M
  - Decrease of 22%
  - Contracts will be adjusted from initial awards

SPE Demonstrations

Detroit LTC Connection

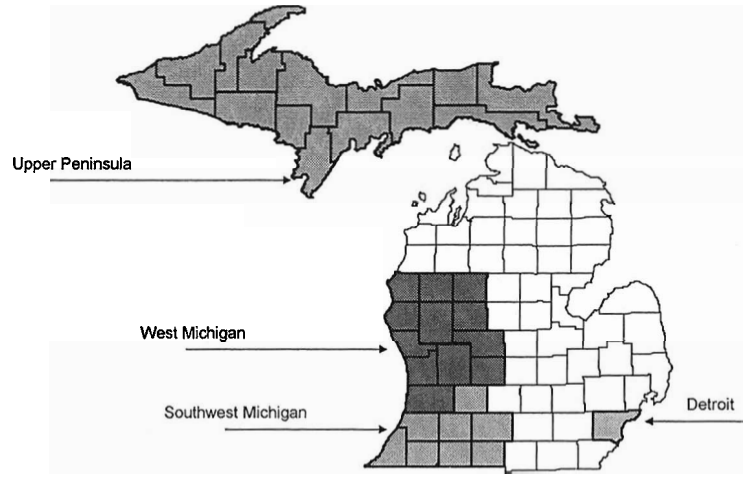
- Submitted by Detroit AAA
- Initially serves PSA 1-A
- Plans to expand to western Wayne County

- West Michigan LTC Connection
  - Developed through a collaboration of HHS, Inc, and Region VIII & XIV AAA's
  - Serves Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Ottawa

SPE Demonstrations

- Southwest Michigan LTC Connection
  - Submitted by Region IV AAA; Region III A, B & C collaborators
  - Serves Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties
- Upper Peninsula LTC Connection
  - Submitted by U.P. Commission for Area Progress (UPCAP)
  - Serves Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Ottawa

SPE DEMONSTRATIONS: Michigan's LTC Connections



2. Contracts

27 month demonstration period (7/1/06 – 9/30/08)

15 month initial contract

- Start-up activities
  - Hire staff
  - Establish governance
  - Establish physical office
  - Conduct local level planning, outreach

Target date for initiation of I&A is 10/1/06

Evolving Concepts

- Firewall from provider interests, to independent entity
- Supports coordination, to enhanced options counseling
- Person Centered Planning, to person centered thinking and full person centered advocacy
- Mandatory level-of-care referrals, to MOU to refer in collaborative agreements
- Information & referral to information and assistance through enhanced system development

I
Independent Entity: Governance

- Governing Board: Providers of direct service to consumers may not be members of the Governing Board nor may individual Governing Board members have a moneyed interest in the LTCC/SPE Agency. The Governing Board must have significant primary and secondary consumer representation.

I
Independent Entity: Governance

- The LTCC Agency must include a Consumer Advisory Board (CAB) within the organization. The chairperson for the CAB must be a primary consumer. A primary consumer is defined as someone who currently receives long-term care services. Providers may be included on the CAB but may not represent more than one-quarter (25%) of the board

Start Up Activities

- Staff job descriptions, hiring
- Board and Consumer Advisory Board
- Incorporation and Bylaws
- Office, phones, computers
- Service Point redesign
- Resource Data base—exclusion inclusion
- Resource Data Base Information Collection
- Consumer educations presentations—development – brochure developed
- Stakeholder groups and meetings
- Staff training curriculum and conducted
- Caregiver – one of 4 state National Caregiver staff training and service system design
- Standards– I and A, Rights, Options Counseling
- LOC Determination policy

Start Up Activities
Calls and Cases

		JAN	FEB	MAR
D.	I and A Calls	2,046	1,748	1,964
	Calls Converted			
E.	**Options Counseling Cases**			
1	Options Counseling Cases Opened	183	156	157
2	Cases Closed			
3	Cases Continuing Open			343

# of contacts

Start Up Activities
Outreach Activities

		JAN	FEB	MAR
F.	**Community Education Presentations**			
1	Number of Presentations	5	8	7
2	Number Present	98	654	826
G.	**Outreach Activities**			
1	Number of Activities	127	83	86
2	Number of brochures distributed	1,240	1.161	1.474

4. Current Development Priorities

- Increase # of information and assistance calls
- Improve use of service point fields
- Customer survey feedback loop
- Develop & increase partnership agreements
  - Nursing facilities
  - MI Choice Waiver Agents
  - Implement the Level-of-Care determination process
- Outreach & marketing
- Establishing local stakeholder networks
  - LTC Providers
    Advocacy organizations
  - Healthcare systems
- Revising and redirecting contracts for last quarter

Future Development Issues

- Mandatory Level of Care Determination
  - Policy
  - Technology
  - Capacity
  - Streamlined experience
- Transition and Diversion Policies & Practices

System Evaluation Questions

- Does the LTC system adjusts and adapts too meet consumer needs and preferences?
- Are people receiving good, reliable, unbiased, useful information to make informed choices?
- Are assessments being completed and eligibility determined within specified guidelines?

Stakeholder Evaluation Questions

- Do providers participate in partnership agreements?
- Do providers understand the use LTCC services?
- Do providers experience efficiencies?

Consumer Evaluation Questions

- Do consumers understand the information provided?
- Do consumers feel their needs have been identified and understood?
- Do consumers feel comfortable with their decisions?

SPE Performance

Consumer experience is the focus of performance monitoring and improvement activities

- Quality assurance activities are monitored and outputs are measured
- Local efforts must align with the minimum expectations of MDCH and the LTCC (indicators and benchmarking)

Anticipated Impacts

- Consumers exercise informed choice.
- Consumers maintain quality of life.
- The LTC system is responsive to consumer needs.
- Coordinated service delivery.
- Improved quality

Michigan's Long Term Care Connections

1-866-642-4582

Project Coordinator: Nora Barkey
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Michigan LTC Commission
Comments of Lynn Kellogg
4/23/2007

Several people approached me to offer an update from the perspective of trying to "birth" the new SPE. In order to be succinct I prepared a brief statement.

The four SPE demonstrations differ from each other. My comments are on the broader issues of the Southwest Michigan LTC Connection [SWMLTCC] model to give you a feel for the rewards and challenges to date.

What have been the rewards?

By far the most exciting, rewarding piece of this entire effort has been and continues to be the degree of discussion and collaboration across the varied disciplines and entities involved in LTC.

The AAAs involved had never teamed for a project and in fact had a history of fractured relations. Many persons knew each other but had never had serious dialogue about future visioning. Forums of stakeholder entities from across the 8 county area began as soon as the RFP was let to share perspectives and jointly compile questions for the bidder's conference and subsequently to talk about the merits and structure of the demonstration.

After extensive discussion with the state and local stakeholders, this is what we have, what we are ready to flip the switch on.

We have a new, independent 501c4 entity. It controls the dollars, all contracts or agreements, the hiring of the director. The lines of authority including hiring and firing of staff run to the director and the new governing board. Staff is decentralized in four locations across the 8 counties and will be decentralized further depending on demand and resources.

Special efforts were made to assure representation by HCAM & MAHSA facilities, DHS, and the Disability Resource Network along with consumers on the governing board and consumer advisory board. Stakeholder dialogue has been extensive. These discussions have evolved into quarterly provider forums, facilitated with assistance by one of the hospitals. Early Options Counselor [OC] work continued these discussions on an individual level.

Three factors have been the uniting force in gaining consistent and broad support:

First **-** the common interest in waving the banner of LTC itself – acknowledging that the state has never been able to move this far before in gaining support for LTC and that it should be taken to the next level – being a bridge across LTC constituencies has been a major role;
Second **-** a commitment to build on existing systems rather than create a different service system and another administrative infrastructure that would sap resources; and
Third **-** that the ability to have input into the work of an SPE best occurs by participation in a demonstration – the trust and commitment of the players involved to work together was in the forefront.

In the SW model administrative support functions are contracted to the four AAAs comprising the southwest region, allowing SWMLTCC's central staff to focus entirely on the development and management of the demonstration. Beyond ability to do administrative task work, AAAs were chosen for strategic reasons.

AAAs across the state vary considerably. Most are private entities. Some are progressive, some are not. The image and reality varies. There are similarities defined by law. To assure objectivity, all are forbidden by statute [the Older Americans Act] from providing direct service except for informational and other linkage or access services. They must conduct assessments of community and caregiver needs to steer resources to high need areas.

Last fall the Older Americans Act was reauthorized and modernized. The changes coming through the Act for the non-Medicaid LTC system are exactly compatible with the direction of Michigan LTC Connection effort. Self-determination, broad collaborative partnerships, provision of information & access services, simplifying old rules, promotion of livable communities for all ages – this will become what AAAs are all about. Most AAAs don't fully realize the paradigm shift coming in their network. That's why Assistant Secretary on Aging Josefina Carbonell is coming to Michigan in May - to tell us about it. Do come hear her if you can.

By using AAAs for administrative support in the SPE demonstration, significant leveraging of additional LTC resources is also achieved. The LTC Connection will influence, or steer AAA resources. Common functions such as community needs assessment and analysis of caregiver needs allows dovetailing of developmental work in the non-Medicaid as well as Medicaid arena – with much broader input than ever before because of all the partnerships being established through the demonstration. The potential scope of collaboration is exciting.

What have been the challenges?

The effort to establish the electronic statewide client tracking and resource data base required in Michigan's ADRC grant, and having to put that effort at the front end of this entire effort, has been a drain of staff time and resources. I'm hopeful it will be a great product, but the staff time needed to iron this out has been monumental – time that could have been focused with stakeholders and consumers in the field.

Also, in what I believe is an effort to respond to state level political tensions and some of the evolution in concept at the state level, there's been almost an obsession to assure the SPE is a separate and new endeavor – something that was not required at all in the task force report, nor in the RFP which required appropriate firewalls. The resulting SW model supports that separation fully by creating a new entity with central staff to govern and manage the project, while also staying true to the commitment to building on existing systems – the premise on which local support was built. But this theme has had to be revisited again and again for assurance and has been exhausting. Oddly enough, the concern with this issue seems to appear only at the state level, not locally. Hopefully it is behind us. Commitment by the local team remains high.

The larger concern locally is that the stakeholders and consumers that supported the SW application so that they could have input and help steer the development of a SPE are now worried that how the SPE will run will become proscriptive, without their input. The concern is compounded by the passage of PA 634. We're working hard to pull that input in as we move along, but we have the same concern ourselves.

Lastly, it feels sometimes like there are two parallel sets of demands on Options Counselors which may or may not be compatible with each other in the end. One scenario assures that an "OC" has adequate time to talk and work with a person to make sure that person has the tools and supports needed to control and manage their universe. The second scenario assures that timely completion of required Medicaid documents is paramount, no matter the volume, complexity or setting. One takes almost unlimited time with people, the other goes faster and faster between people.

These two sets of demands and the resulting discussion is further compounded by budget issues and the reality that there simply may not be the level of staffing available as originally intended.

It's been interesting. I don't sit in on any of the hiring, but I did with some of the initial staff. Some of the initial prerequisites for working on the project included positive energy, absolute commitment, a tolerance for vagary, and a sense of humor. Good traits – they still hold true.

Thank you for asking how it's going.

Preliminary Report of the A Team (Workgroup A) of the Governor's Task Force on Medicaid Long Term Care

September 13, 2004
As changed by the Full Task Force on November 8, 2004

General Principles as Adopted to Date:

Adopted Principles:

- **The Single Point of Entry Agency utilizes person-centered planning principles and practices throughout its functions.**

- **Money follows the person.**
  - The amount of money paid to cover the services a person will receive would be based on the acuity of the client rather than the costs of the provider.

- **The Single Point of Entry agencies should be locally or regionally based.**
  - Consumers are best served by agencies which understand and harness local resources as well as state and federal funding sources.

- **Access should be consumer-centered and user-friendly. Tools used should be universal regardless of location of SPE agency.**
  - While SPE agencies need to be locally or regionally based, the tools should be the same regardless of location. This provides ease of use, consistency, evaluation and quality assurance.

- **All systems need to comply with HIPAA.**

Adopted Features that Need to Be Operationalized:

- **Phased in Implementation: Supportive of a relatively short phase in. The Department (MDCH) or Task Force should undertake a careful evaluation of early adopters to see if the they are achieving anticipated results. It is anticipated the information will be used to guide future implementation. The end goal is an SPE that is available to everyone in Michigan. Three year implementation period to achieve the goal.**
  - The Workgroup consciously decided to avoid the use of the word pilot because it may inadvertently imply a lack of commitment to having an SPE system. The recommendation is to start with "early adopters" who meet the criteria and roll out the system over a three year period.

- **The system needs to be based on a standard set of criteria set by the State.**
    - By making a standard set of criteria, the State will be able to do data gathering and evaluation, have quality assurance standards and provide for consistency for consumers and stakeholders.

- **Locally or regionally decided which agency to recommend to the State. The State has final approval.**
    - It is important for local and regional stakeholders to be involved in the recommendation of which agency can best serve the constituents of a particular area. The State needs to ensure the recommended agency can meet the standards set by the State.

- **There should be an appeals process (with the assumption that it will be part of the criteria). It should have an internal and external component as well as monitoring and resolution.**
    - Having multiple levels of appeal is of extreme importance to persons in need of long term care and to the system providing that long term care. The appeals process provides an opportunity for review of individual decisions and can assist in uncovering possible patterns of behavior by agencies.

- **There should be a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction.**
    - Quality assurance functions can focus on many things in a given system. The Workgroup is recommending the most comprehensive approach to quality assurance including measures of consumer satisfaction with the system.

- **There should be an outside advocate on behalf of what the person wants.**
    - The long term care system can feel overwhelming to any person even if all of the best systems are in place. An outside advocate specifically charged with representing the person's needs is essential in helping a person navigate a fairly complex system when he or she feels extra help is needed.

- **Build in as much control and choice for the person as possible through person centered planning.**
    - The Workgroup feels this essential to the incorporation of the value of person-centered planning as well as good business sense.

<u>Other Actions:</u>

- **A state government agency or individual should lead the long term care effort. (Referred to Workgroup E)**
    - While members of Workgroup A felt this is crucial to the development of an actual system of long term care, they also felt it was most appropriately handled by Workgroup E.

Workgroup A

Single Point of Entry and Person Centered Planning

Decision Document – Retreat

October 5th and 6th, 2004

Presented to the Governor's Medicaid Long Term Care Task Force on October 11, 2004
As changed by the full Task Force on November 8, 2004

I. Information and Referral/Assistance

a. SPE agencies will do Information and Referral/Assistance as it is a critical function for all consumers. The agencies will provide Information and Referral/Assistance on any and all services and supports that individuals need for long term care. They also will serve as a resource on long term care for the community at large and caregivers.

II. Financial Eligibility Determination

a. Financial eligibility determination for Medicaid-funded programs will be determined by the appropriate State agency. The SPE agencies will provide assistance to consumers in working through the process. The SPE agencies can facilitate speedier processing and identify any barriers to processing. They should also work with other agencies to resolve barriers found in the system.

III. Case Coordination/Supports Coordination/Care Planning

a. Case and Supports Coordination will be a key role of the SPE agencies.
b. Consumers have the ability to change Care (Supports) Coordinators when they feel it is necessary to do so.
c. Individuals will be able to develop their care or support plans through the Person-Centered Planning process.

IV. Transition Coordination and Facilitation

a. Nursing home transition will be a function of the SPE agencies. This service offers choice for NH residents, involves consumers in making decisions about their own lives, and facilitates a smooth transition into community living.

V. Option for Independent Person Centered Planning Facilitation

a. Whether the facilitator is paid or unpaid, Independent Person Centered Planning (PCP) Facilitation should be an option for persons in the LTC system.

b. The A Team is referring the decision on whether Medicaid can pay Independent PCP facilitators to Workgroup B.

VI. Balancing of Long Term Care through Proactive Choice Counseling

a. The goal of Proactive Long Term Care Choice Counseling is to catch people with long term care needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their long term care options.

VII. The SPE is mandatory for those eligible for Medicaid funded programs.

a. Use of the SPE agency is mandatory for individuals seeking to access publicly funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance functions will be available to everyone at no cost. Private pay individuals may have to pay a fee to access other SPE services (in addition, these services may be covered by long term care or other insurance). Long Term Care providers will be required to inform consumers of the availability of the SPE agency.

VIII. Comprehensive Level of Care Tool

a. A comprehensive assessment, or Level of Care Tool, will be available from the SPE agencies to determine functional eligibility for publicly funded long term care programs including Home Help, Home Health, HCBS waiver, and nursing facilities.
b. SPE agencies will use the Comprehensive Level of Care Tool for <u>all</u> persons coming to the SPE for assessment.

IX. Universal Use of the Level of Care Determination Tool

a. All providers of long term care services will be required to offer the Level of Care Tool to consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function.

X. Functional Eligibility Determination will be located in an SPE Agency as long as there is aggressive state oversight and quality assurance including:

a. SPE agency required procedures to prevent bias and promote appropriate services;
b. SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination;
c. State quality assurance monitoring; and
d. Patient advocate and Ombudsman monitoring

XI. Separation of Service Authorization and Service Provision

a. The following recommendation is sent to Workgroup B: There should be intensive deliberation regarding:
    i. the finance mechanisms for funding services (managed care or fee-for-service) and whether services are paid by the state or the local SPE agency.
    ii. The balancing of provider certification with the value of consumer choice through person centered planning.
b. The SPE should do Service Authorization.
c. The SPE should not do Direct Service Provision.

XII. Implications of Direct Service and Single Point of Entry

a. The SPE agencies cannot be a provider of Medicaid services to eliminate the tendency to recommend its own services to consumers.
b. Services provided by Area Agencies on Aging (AAAs) through the Older Americans Act are not considered Medicaid services and do not pose a barrier for AAAs seeking to become the SPE agencies
    i. Non-AAA waiver agencies are also eligible to apply to be an SPE agency.
c. The case management currently done by Waiver agents will move to SPE agencies under this system.
d. The case management done by FIA for Home Help would now move to SPE agencies in this system.
e. SPE agencies will encompass the entire range of publicly funded LTC services from the lower acuity (for example, Home Help) to higher acuity (such as skilled nursing facilities and waiver services).

Workgroup A – Single Point of Entry and Person- Centered Planning
Minority Report
Deanna Mitchell
October 8, 2004

Issue: Should the activity of Functional Eligibility Determination be included in the proposed Single Point of Entry Model

Although technically the final question regarding the above issue was directed at inclusion of the task of functional eligibility determination in the service delivery model, the real issue was whether it is appropriate to build a system that includes all possible functions. Although many other states have developed all-inclusive programs, there are consequences that can be difficult to monitor and control.

1. **Resource centers and information and referral should be community-based activities that are not directly related to publicly or privately funded service programs**. Historically, when community information and referral (I/R) activities are housed and directed by the same management that directs coordination of services, there often is a loss of the breadth of knowledge and initiative toward community and informal resources, since the focus is on the publicly funded program. When the publicly funded program is limited, creative problem solving tends to be even more limited.

2. **Functional eligibility decisions should not be made by the same organization that coordinates or supervises care in the community.** When there is limited availability of publicly-funded program opportunities, or funding for individual services is limited, there is a high potential for steering consumers to choices and decisions that benefit the organization, and not necessarily the consumer. In addition, limitation of resources in certain geographic regions and perceived difficulties in maintaining a specific consumer in the community also have affected organizational decision-making.

   Functional eligibility decisions involve more than simple application of an algorithm; there needs to be an explicit discussion of consumer options and opportunity for a specific choice. Assistance with consumer decision-making must be independent and free from all bias as much as possible. It is very difficult to effectively monitor and control this kind of bias in the system.

3. **The continuity of care delivered through an all-inclusive system does not outweigh the bias.** There are easy methods to eliminate any loss of continuity in enrollment that very effectively address continuity issues when functions are appropriately separated. An example of this may be co-location of functions in the same place, although managed by separate

organizations. In addition, the current referral process used to assist persons in obtaining services is inadequate. The responsibility for timely contact, additional information, and service initiation must be taken on by the provider – regardless of the model. There are many possible methods for the enrollment agency to ensure that services have been initiated.

4. **An all-inclusive system only works for current FFS or HCBS waiver programs.** An integrated system of care, or a managed care model, must include a complete separation of functional eligibility and consumer choice. By building such a system, Michigan will be limited in its choices of delivery model, or be faced with a system that must be changed if an integrated care model is desired.

5. **Consumer choice needs to drive the options for long term care:** developing an all-inclusive model that does not build independent interest into the system at the start is a missed opportunity.

THE UNDERSIGNED NON-AAA WAIVER AGENTS SUBMIT THIS MINORITY REPORT ON SINGLE POINT OF ENTRY FOR LONG -TERM CARE REFORM TO THE GOVERNOR'S TASK FORCE ON LTC.

PROBLEM A: MOST PEOPLE DO NOT KNOW ABOUT THEIR LONG-TERM OPTIONS. PARTICIPANTS NEED A STATEWIDE SET OF CRITERIA AT AN SPE.

SOLUTION TO A: AN EASILY FORMULATED OUTREACH PROGRAM WITH ONE 800 # THAT CAN BE AUTOMATICALLY VOICE DIRECTED TO EACH LOCAL INFORMATION CENTER THAT IS DIVIDED BY THE CURRENT 14 REGIONS THAT MICHIGAN STATE WAIVER AGENTS SERVE. ALL STATE AND LOCAL GOVERNMENTAL AGENCIES AND NGO ENTITIES ADVERTISE AND DIRECT INDIVIDUALS TO THIS 800 #. CMS THROUGH THE MOLLICA REPORT ON SINGLE POINT OF ENTRY CLEARLY DEFINES A WAIVER AGENT.

EXHIBIT #1 FROM MOLLICA & GILLESPIE, (2003) p1.

"State agency field offices are the type of organization that most frequently acts as the SEP, followed by community-based nonprofits and area agencies on aging"

"SEPs perform a range of functions. All SEPs develop care or individual service plans, and monitor service delivery. Most also complete assessments, authorize services and complete periodic reassessments. Seventeen SEPs determine financial and functional eligibility. Twenty-four conduct nursing facility preadmission screening."

"All but one of the SEPs (42) provide access to Medicaid home and community-based services funded programs, 35 provide access to programs funded by state general revenues and 26 manage Medicaid state plan services. Just over half (54%) of the SEPs serving older adults provide access to older Americans Act Funded Services."

"Nearly half (47%) of SEPs take advantage of technology. Care managers use computerized assessments in 20 SEPs and another 4% are planning to implement computerized assessments."

PROBLEM B: TOO MANY ENTITIES PROVIDE INFORMATION THAT IS INCORRECT OR INCOMPLETE. THE REQUIRED INFORMATION SHOULD BE MADE AVAILABLE BY REGION BASED ON STATE AND CMS CRITERIA.

SEE EXHIBIT 2 FROM MOLLICA & GILLESPIE, (2003) p3, 4.

"In their broadest form, SEPs perform a range of activities that may include information and assistance, referral, initial screen, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring and periodic reassessments. SEPs may also provide protective services."

"One or more sources of financing, typically Medicaid, state general revenues, Older Americans Act, Social Services Block Grant, county funds or fee charged to consumers may be used to pay for services. SEPs also coordinate service delivery with other community organizations and programs that might be available outside the SEPs control. SEPs may utilize Internet websites to provide information or screening tools that help consumers and family members understand their needs and the resources available to them. Organizations that only provide information and referral do not fall under this operational definition."

SOLUTION TO B: THE CURRENT WAIVER AGENTS (21) IN THE STATE OF MICHIGAN HAVE BEEN WORKING WITH THE SAME BASIC SET OF RULES FOR OVER TEN YEARS AND POSSESS THE BROADEST RANGE OF KNOWLEDGE ON THE SUBJECT OF LONG-TERM CARE OF ANY OTHER ENTITIES THAT COVER THE ENTIRE STATE OF MICHIGAN. THIS INCLUDES ALL OF THE ACTIVITIES SET FORTH ABOVE IN EXHIBIT 2 AND COVERS CMS REQUIREMENTS. WAIVER AGENTS NOW DEAL WITH APPEALS PROCESS AND CAN IMPLEMENT A STATEWIDE APPEALS PROCESS THAT MEETS STATE AND CMS CRITERIA.

PROBLEM C: A SINGLE LOCATION TO ANSWER QUESTIONS FROM THE ENTIRE STATE OF MICHIGAN CANNOT ADEQUATELY KNOW THE LOCAL AVAILABILITY OF SERVICES, PROVIDERS AND OPTIONS THAT WOULD PROVIDE THE REQUISITE CHOICE THAT EACH INDIVIDUAL IS ENTITLED TO HAVE.

EXHIBIT 3 FROM MOLLICA & GILLESPIE, (2003) p 5.

"In one model, services are accessed through a single access point. The other model will provide access to services through multiple but highly coordinated access points, referred to as a 'no wrong door approach'."

SOLUTION TO C: EACH INDIVIDUAL IS ENTITLED TO KNOW ALL THE LOCAL OPTIONS AVAILABLE SO S/HE CAN EXERCISE AN INFORMED DISCRETION AS TO EACH PERSON'S INDIVIDUAL NEEDS. ONLY THE 21 WAIVER AGENTS IN THE 14 REGIONS DEAL WITH ALL OF THE LOCAL PROVIDERS AND HAVE EXPERIENCE AS CARE MANAGERS, AS WELL AS EXPERIENCE IN THE "FREEDOM OF CHOICE" THAT THE OLMSTEAD CASE REQUIRES. THIS AND THE OTHER FACETS OF WAIVER AGENT DUTIES QUALIFY THE 21 WAIVER AGENTS TO PROVIDE A NETWORK OF EXPERTS ON ALL FACETS OF LONG-TERM CARE AND, MOST IMPORTANT, PROVIDES A SINGLE POINT OF ENTRY THAT COULD BE SET UP AND IMPLEMENTED IN A VERY SHORT TIME, PROBABLY WEEKS AT THE LONGEST. ALL OF THE ABOVE ARE CMS PRIORITIES. CURRENT REQUIREMENTS FOR WAIVER AGENTS INCLUDE QUALITY ASSURANCE AND QUALITY IMPROVEMENT, WHICH INCLUDES A CONSUMER SATISFACTION COMPONENT.

PROBLEM D:LOCAL KNOWLEDGE IS NECESSARY TO GIVE THE INDIVIDUAL THE PERSONAL CHOICES THAT WILL ALLOW EVERYONE'S NEED TO BE MET AND AT THE SAME TIME PROVIDE FOR THESE NEEDS AT A LEVEL OF CARE REQUIRED FOR EACH INDIVIDUAL AT THE MOST FAVORABLE COST TO THE INDIVIDUAL AND THE STATE OF MICHIGAN.

EXHIBIT 4 FROM MOLLICA & GILLESPIE, (2003) p 10.

"A few states have addressed the barrier to community placement by allowing case managers to 'presume' eligibility when an initial review of the person's circumstances indicate the person is likely to be eligible. Services can be initiated and authorized for up to 90 days while the Medicaid application is completed and a determination is made. If the person is found to be ineligible, federal Medicaid reimbursement is not available. Nebraska, Oregon and Washington allow case managers to presume eligibility the president's proposed budget for fiscal year 2004 includes a presumptive eligibility provision that would allow states to receive federal reimbursement for services that were provided for up to 90 days to people being discharged to home from a hospital who were later found ineligible for Medicaid."

SOLUTION TO D: WAIVER AGENTS HAVE BEEN REQUIRED TO DETERMINE THE LEVEL OF NEED AND THE TYPE OF SERVICES THAT ARE REQUIRED TO MEET WHATEVER LEVEL OF NEED THE INDIVIDUAL WOULD CHOOSE. CHOICE HAS ALWAYS BEEN THE MAJOR CRITERION THAT WAIVER AGENTS HAVE EXERCISED IN MEETING THEIR CONTRACTUAL OBLIGATIONS TO THE PUBLIC, THE STATE OF MICHIGAN AND CMS. WAIVER AGENTS HAVE ALSO BEEN REQUIRED TO MEET THE INDIVIDUAL NEEDS AND REQUIREMENTS OF THE LONG-TERM CARE RECIPIENTS AT A COST LEVEL THAT IS PROBABLY THE MOST EFFECTIVE RATE OF ANY OTHER LONG-TERM CARE FACILITATOR OR PROVIDER IN THE STATE OF MICHIGAN. WAIVER AGENTS CURRENTLY KNOW THE AVAILABLE OUTSIDE ADVOCATES IN THEIR LOCAL REGIONS, SO IMMEDIATE REFERRALS CAN BE GIVEN. ALL WAIVER AGENTS HAVE NURSE CASE MANAGERS.

EXHIBIT 5 FROM MOLLICA & GILLESPIE, (2003) p 13.

CARE MANAGEMENT TERMS AND ASSESSMENT

"Early SEP models assigned a case manager to each consumer. Policymakers have designed more sophisticated care management processes. In some systems, registered RNs serve as consultants to the case manager, advising about risk factors and health conditions that might warrant a referral to a home health agency or contact with the physician. Other states formed teams of social workers and registered nurses. Nurses may conduct the assessment and develop the care plan when there are unstable medical conditions or conditions that require skilled monitoring or observation. Either the social worker/care manager or an RN completes the assessment in 26 SEPs. In one, only the case manager completes the assessment in two SEPs."

PROBLEM E: A SINGLE 800 # MUST BE WIDELY DISSEMINATED THAT AUTOMATICALLY DIRECTS THE CALLER TO A LOCAL WAIVER AGENT AS THE DESIGNATED INFORMATION PROVIDER.

SOLUTION TO E: ONE (1) 800 NUMBER. AUTOMATIC VOICE DIRECTION TO EACH REGION. LOCAL EXPERTISE FROM THE WAIVER AGENTS IN EACH REGION COULD PROVIDE TREMENDOUS EFFICIENCY, IMMEDIATE IMPACT, OUTSTANDING LEVEL OF SERVICE TO THE LONG-TERM CARE RECIPIENT IN MICHIGAN AND AT AN EXTREMELY COMPETITIVE COST THAT WOULD ALLOW MANY MORE RECIPIENTS THE LONG-TERM CARE THEY NEED AND WANT. THE CALLS CAN BE ALTERNATED BETWEEN WAIVER AGENTS IN EACH DISTRICT BY AUTOMATIC PHONE TRANSFER.

FINAL SOLUTION: FUTURE LTC IN MICHIGAN WILL BE REQUIRED TO CONFORM WITH PROGRAMMATIC STANDARDS THAT ARE ESTABLISHED BY CMS. FEDERAL MONEY IS A REQUIREMENT OF LTC FINANCING. THUS, CMS REQUIREMENTS MUST BE MET BY MICHIGAN LTC IF ANY REALISTIC EXPECTATIONS FOR APPROVAL OF THE PROGRAMS ARE TO BE SUCCESSFUL.

SINGLE POINT OF ENTRY IS CMS'S SOLUTION TO INDIVIDUAL CHOICE LTC. WAIVER AGENTS ARE THE CLOSEST ENTITIES TO THE PREFERRED APPROACH THAT CMS HAS ENDORSED THROUGH IMPLEMENTATION AND STUDIES SUCH AS THE *MOLLICA REPORT*. *PRAGMATIC THINKING WOULD REQUIRE MICHIGAN LTC ADVOCATES TO PROPOSE THE ABOVE SOLUTIONS BY NAMING WAIVER AGENTS AS THE SINGLE POINT OF ENTRY.*

EXHIBIT 6 FROM MOLLICA & GILLESPIE, (2003) p 16, 17.

"This survey identified some common elements across SEPs; most serve older adults and people with physical disabilities, control multiple funding sources and require care managers to have a minimum of a bachelor's degree. There is also considerable variation among SEPs in the functions they perform and in the organizations that function as the SEP. Based on the degree of integration of populations served functions performed and funding streams accessed, SEPs can be arrayed along a continuum. The survey finding suggests that there is room for further progress by increasing the populations, functions and funding sources managed by SEPs."

Populations. "SEPs that serve multiple populations may achieve economies of scale and streamline SEP/provider agency relationships."

Functions. "Combining financial and functional eligibility determinations or improving coordination would expedite access to home and community-based services."

Financing. "SEPs that coordinate funding from medicaid state plans, HCBS waiver and state general revenue programs have more flexibility to respond to varying individual needs than programs that manage only HCBS waiver funds. Of course, during a period of declining revenues, states operating programs with general revenues may be seeking ways to maximize revenue and cost effectiveness by shifting services to programs that are financed with federal funds. The AoA and CMS-supported aging and disability resource centers will coordinate all Medicaid-funded, long-term support services, which includes both Medicaid state plans and HCBS waiver services, as well as older Americans Act Funded Services."

THIS PROGRAM HAS AN ELEMENT THAT OFFERS ONE OF THE RAREST AND MOST DESIRABLE ASPECTS OF PUBLIC SERVICE. IT IS SIMPLE, SIMPLE, SIMPLE! MICHIGAN NEEDS FAST ACTION TO BEGIN THE SOLUTION TO LTC.

THE WAIVER PROGRAM IS CURRENTLY BASED UPON THE CONTROL AND CHOICE OF THE CONSUMER, AND NO NEW LEARNING CURVE WOULD BE REQUIRED OF THE SPE FUNCTIONS. WAIVER AGENTS ARE VIRTUALLY DEFINED BY THE PRELIMINARY REPORT OF THE WORK GROUP A CONSIDERING SINGLE POINT OF ENTRY CHAIRED BY SUSAN STEINKE.

Exhibits come from:

Single Entry Systems
State Survey Results
Funded by Centers for Medicare and Medicaid Services
Prepared by:
Robert Mollica and Jennifer Gillespie
National Academy for State Health Policy-August 2003

Dated: August 26, 2004.

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SENIOR SERVICES, INC.
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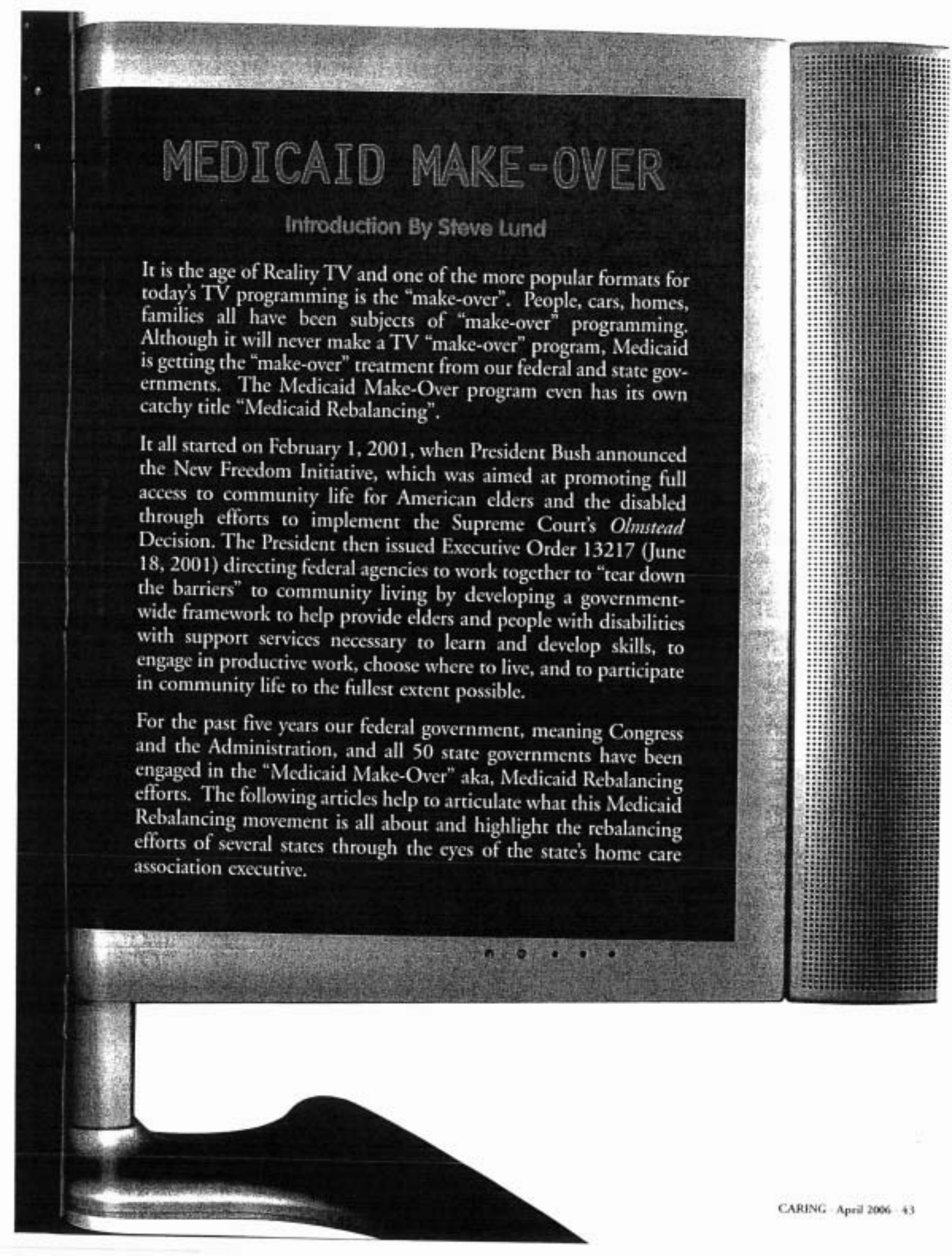

MEDICAID MAKE-OVER

Introduction By Steve Lund

It is the age of Reality TV and one of the more popular formats for today's TV programming is the "make-over". People, cars, homes, families all have been subjects of "make-over" programming. Although it will never make a TV "make-over" program, Medicaid is getting the "make-over" treatment from our federal and state governments. The Medicaid Make-Over program even has its own catchy title "Medicaid Rebalancing".

It all started on February 1, 2001, when President Bush announced the New Freedom Initiative, which was aimed at promoting full access to community life for American elders and the disabled through efforts to implement the Supreme Court's *Olmstead* Decision. The President then issued Executive Order 13217 (June 18, 2001) directing federal agencies to work together to "tear down the barriers" to community living by developing a government-wide framework to help provide elders and people with disabilities with support services necessary to learn and develop skills, to engage in productive work, choose where to live, and to participate in community life to the fullest extent possible.

For the past five years our federal government, meaning Congress and the Administration, and all 50 state governments have been engaged in the "Medicaid Make-Over" aka, Medicaid Rebalancing efforts. The following articles help to articulate what this Medicaid Rebalancing movement is all about and highlight the rebalancing efforts of several states through the eyes of the state's home care association executive.

The Carolinas Are Calling! Making the Case for Telehomecare!

By Tim Rogers

Imagine that you are a patient with congestive heart failure due to coronary artery disease. On bad days you are so short of breath that you find it extremely difficult to walk the length of your living room and your feet are so swollen you cannot get your bedroom shoes on. Over the past four months, you have had four hospitalizations when you have felt so starved for air that you felt you were dying. After your last hospitalization, your physician ordered home health nursing and telehomecare. Since home health telemonitoring, you have had only one hospitalization in six months and no unscheduled physician visits – saving the public payers thousands of health care dollars and greatly enhancing your quality of life.

And such is the case for telehomecare being presented by both the Association for Home & Hospice Care of North Carolina (AHHC) to the North Carolina Legislators and the North Carolina Division of Medical Assistance and the South Carolina Home Care Association (SCHCA) to South Carolina Medicaid. (AHHC also manages the SCHCA).

Cardiovascular diseases are leading chronic illnesses in both states, particularly among our African American, the under served and rural residents. With 45 percent of the American population affected by one or more chronic illnesses consuming approximately 78 percent of all healthcare spending in the United States, utilizing home monitoring as a component of disease management just makes good fiscal sense for states.

The association staff researched telehealth utilization and outcomes, collected data from home health agencies using telehealth, and then developed a concept paper for both states' Medicaid programs. Included in the concept papers was an interview with Jude Lauffer, RN, Cardiac Disease Management Specialist with Gateway Health Plan whose company is managing Pennsylvania Medicaid patients. She reported that Gateway has a cardiac disease management program utilizing home health agencies to provide telehealth services. To qualify for monitoring, patients need to have greater than one hospital admit in a 12 month period for CHF. Medicaid reimburses a daily per diem to have the monitor in the home and the results followed by home health. They reimburse for skilled visits as needed in addition to the daily per diem. For the 44 patients in the project demonstration, they have achieved a 27 percent reduction in hospital admissions.

At Baptist Hospital Home Care in Winston-Salem, North Carolina, utilizing telemonitoring for 21 home health patients studied greatly impacted total hospital in-patient days and admissions. Mike Waid, Administrator, reported a decrease in total inpatient days from 405 to 153, and a decrease in admissions from 64 to 23. As you can see, using data such as this is crucial in making the case for telehomecare. Our legislators and Medicaid directors deal in the world of dwindling health care budgets. They have to see the return on investment when considering new programs. And with other provider settings competing for those health care dollars, we also have to keep reminding everyone that citizens and their families prefer to stay home. Telemonitoring gives those patients who are most acute the confidence and security they need to do it.

With CMS's current interest in home telehealth and with the help of the Quality Improvement Organizations (QIOs), agencies should take full advantage at this time to implement the strategies needed to reduce rehospitalizations. The home health community has struggled over the years to demonstrate its true value to the federal government and to the states. We are fortunate in that we see our worth daily in the faces of the patients under our care. Now we have a great opportunity to validate home health's value by decreasing hospitalization rates. AHHC and SCHCA see improving this outcome as one of our number one priorities in the coming year as our members prepare for pay for performance.

AHHC is in the process of developing a telehomecare partnership with North Carolina Medicaid and the North Carolina Community Care Program, a program that utilizes physicians to act as gatekeepers to some North Carolina Medicaid services. SCHCA representatives are setting up meetings with South Carolina Medicaid staff to discuss the feasibility of a telehealth pilot project in the state.

The Association for Home and Hospice Care of North Carolina (AHHC) is comprised of over 720 agency members including 96 percent of the certified home health agencies and the largest non-certified home care agencies. The SCHCA recently contracted with AHHC-North Carolina to provide association management and within the past 15 months of this contract, SC membership has increased 180 percent, and includes 68 percent of the certified agencies.

About the Author: *Tim Rogers, BA, is executive vice president for both the Association for Home & Hospice Care North Carolina and South Carolina Home Care Association. Under his leadership, membership as grown to over 700 agency members in NC and a 180% growth rate in SC in one year. He is also Chairman of the Forum of State Associations and is a NAHC Board member. Tim can be reached at timrogers@homeandhospicecare.org.*

Florida's Medicaid Reform Proposal

By Gene Tischer

Governor Jeb Bush has established Medicaid Reform as his top public policy priority for 2006. The impetus for this focus is the size and growth of the Medicaid program. In Florida, this is a $15 billion program that serves some 2.2 million Floridians. The governor called the annual cost increases in the program "unsustainable", and he is

In October 2005, Governor Bush secured a vote from state lawmakers to submit a plan to the Department of Health and Human Services (HHS), to obtain a Section 1115 "waiver", i.e., permission to make major changes in the program. The waiver is necessary because the federal government contributes nearly 60 percent of the money for the Florida Medicaid program.

The federal government approved a five-year waiver on October 19; although the agreement says the waiver can be renegotiated if there are significant changes to Medicaid on the federal level (such as cuts in the budget to curtail sharp increases in federal spending). In his letter of approval, HHS Secretary Michael Leavitt wrote: "[Governor Bush] has introduced competition and consumer choice that will immeasurably improve the quality of care. We're empowering beneficiaries to play a more active role in their healthcare decisions."

Notably, in the final legislative action in October, at the insistence of the state senate, the legislature mandated that the proposal be scaled back. Therefore, the waiver submitted was limited to a request for a pilot program to be implemented in Broward (Fort Lauderdale) and Duval (Jacksonville) counties.

Under the Governor's plan, in the pilot counties, Medicaid recipients will enroll in managed-care plans that can, supposedly, better cut costs and encourage patients to undergo preventive measures. Patients will be given competing plans to choose from — most likely HMOs — although state officials predict that physician networks and hospitals may also band together to offer services.

Not everyone is sharing the enthusiasm. Many of our association members are concerned about the effect these private plans will have on access to home care services. Along this line, the AARP openly questioned the idea of giving more control to outside insurance companies and HMOs, citing recent reports of other state services not getting to recipients.

But this pilot is moving forward. Federal authorities said they want to see if the program is working before it is expanded statewide. Interestingly, the new Medicaid program does not affect nursing home patients and would not curtail benefits for children and pregnant women.

One huge sticking point between the feds and the state was Florida's insistence that payments to hospitals be protected. Both sides agreed to allow hospitals to collect up to $1 billion a year in reimbursements, up from this past year's $688 million. Unfortunately, but not unexpectedly, there is no such protection for any other provider group, including home care.

The transformation will begin in Broward and Duval counties in July 2006, and will affect more than 200,000 people, 140,000 of them in Broward.

The Governor's Guiding Principles of the Plan to Transform Florida Medicaid are as follows:

- Customized benefit packages will allow health plans to meet the unique needs of participants. With the help of independent choice counselors, participants will be able to select a benefit package that best meets their needs.
- Medicaid participants will be able to opt-out of Medicaid entirely and use their state-allocated Medicaid premium to participate in their employer-sponsored health care plan.
- Credits for approved health related expenses like over-the-counter medications, smoking cessation classes and other non-covered health services will encourage participants to engage in healthy lifestyle choices, improving health and lowering acute care costs while providing access to health items not covered by Medicaid.
- Transparency among plans will be critical in empowering consumers. All plans will be required to collect and report information such as consumer satisfaction, percentage of children who receive annual physicals and preventive dental care, and waiting times for consumers assistance, among other measures.
- Provider groups will have greater flexibility in forming and designing benefit plans that serve the medical needs of enrollees with strict oversight from the state. Providers will attract membership on the basis of their benefit package, innovative care, convenient networks and optional services. Consumer satisfaction data collected by the state will help participants make informed choices about the plan that best fits their needs.

- Each plan will be measured on quality, giving policymakers best practices to continually improve healthcare for Florida's Medicaid participants and help close the gap of minority health disparities.
- Market forces will reduce fraud in Medicaid. Because the current Medicaid system pays claims first and identifies fraud later, there is virtually no certain way to control fraud and abuse. Under proposed reform, health plans have a financial incentive to aggressively guard against fraud. Plans will be required to report overpayments to the state and will be able to identify fraudulent providers within their networks.

Florida's Medicaid reform does not change the following:

- Eligibility for Medicaid.
- The requirements for Early and Periodic Screening, Diagnosis and Treatment for children.
- No limits will be established for medically necessary services for children and pregnant woman.
- No cuts in services or spending will occur but Florida will secure better value for its investment through innovation in benefits and services.

Many aspects of the agreement are still unresolved. For example, federal and state officials agreed to pay up to $1 billion a year for the "low income pool," a pot of money reserved for "safety net" hospitals to care for uninsured people. But there is not, as yet, any agreement that details the method to determine how much each hospital should receive or how the money would be distributed.

Other unresolved issues include a detailed state plan to evaluate the plan as it is implemented and requirements for people who seek to opt out of the Medicaid program and use the money to purchase employer-sponsored health care.

Other critics say the Florida plan will replace promised medical benefits with a ceiling on per-person spending. Each beneficiary in the pilot counties must join a managed-care plan. Medicaid sends the insurer a check, based on the beneficiary's recent medical history. Whether that person actually needs only $500 worth of routine care or a $200,000 heart transplant, not a penny more will be forthcoming from Medicaid. A patient denied coverage for a treatment would have to fight with the insurer.

Other critics say the plan changes Medicaid from a defined-benefit plan to a defined-contribution plan, tied to the government's alleged ability to pay. AARP and others wonder what happens when unemployment rises or a dozen big employers decide to stop providing health benefits? Government could simply plead poverty, squeeze the per-person limit for coverage and let the insurers deliver the bad news to patients. The Florida plan, according to the critics, allows the government to wash its hands of the very sickest Medicaid patients.

In summary, the key components of this privatization effort are:

- Florida can establish a premium-based system that uses Medicaid funds to purchase managed care coverage for eligible groups.
- The state can certify a variety of managed care plans including HMOs, provider service networks, and other insurance plans to participate in the reform program.
- Consumers can direct the Medicaid premium to the certified plan they choose to meet their healthcare needs.
- The plans offered to consumers can vary their benefits as long as the state certifies the plans are actuarially sound and sufficient to meet medical needs.
- Consumers can opt out of Medicaid and use their premium dollars to pay for employer sponsored health insurance.
- The state is allowed to spend up to $1 billion in supplemental payments to hospitals each year of the waiver.
- The state can establish Enhanced Benefit Accounts as incentives to participants to follow healthy practices. The federal match will be provided for the funds in the enhanced benefit account as they are earned by consumers. Consumers will be able to access these accounts for up to 3 years after they are no longer eligible for Medicaid.
- The state can use the financing strategy of directing premiums to comprehensive and catastrophic coverage as a means of limiting risk for plans and reinsuring certain qualified plans.
- Premiums can be risk adjusted to account for health status of the participants.

What does this transformation plan, if successful, mean for our home care providers? It could result in more Medicaid care being directed to us. These insurance plans are bottom-line driven. If we are correct, in our oft-stated assertion, that home care saves money, they will slowly, but inevitably, direct more care to us so we can save them money. However, the corollary is also true. If our services are additive and not substitutive, if we add costs and do not save the system money, we will receive fewer and fewer requests for our services.

This pilot program is more than just about Medicaid – it may also help us demonstrate, once and for all, that we are one of the key solutions to the looming crisis of ever-increasing health care costs. And would not that be a wonderful outcome?!

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Increasing Needs in New Mexico

By Joie Glenn

New Mexico continues to prepare for an increase in the number of people needing long term services with a number of initiatives. According to a November 2005 report, by 2030, persons 65 years and older will comprise 26 percent of the state's population, while those over 85 years are expected to grow at a faster rate. Twenty-five percent, or 300,000 of adult, non-institutionalized New Mexicans report having a disability. Age is an important factor in disability, with older age groups clearly having a higher burden of disability than younger age groups. Among those with a disability requiring assistance, Hispanics have the highest need at 7.3 percent, followed by White-non-Hispanic at 6.4 percent, and Native Americans at 4.6 percent. Between 1,800 and 3,000 New Mexican's will have a dual diagnosis of mental retardation/developmental disabilities (MR/DD) and mental illness.

In preparing for this increase in need for long term services, a look at current spending in a "snap shot view" allows for meaningful dialogue and a more real look at the potential gaps and where monies might be shuffled.

Medicaid Long Term Services Expenditures, by Program SFY 2005 Source: NM HSD, HCFA 372, Include: Program Services & Primary/Acute Care State Plan Benefits (Fee-for-Service Claims and SALUD (Capitated)

Intermediate Care Facility/ Mentally Retarded	$22,919,718	(3%)
Nursing Facilities	$220,229,962	(28%)
Program All-Inclusive Care for the Elderly	$6,729,107	(1%)
Personal Care Option	$212,596,536	(27%)
Developmentally Disabled Waiver	$249,840,397	(33%)
HIV/AIDS	$345,286	(.04%)
Disabled & Elderly Waiver	$55,418,097	(7%)
Medically Fragile Waiver	$6,672,630	(1%)

Total=$775 million

In recognition of the expenditures going into long term care policy and management, several groups including state agencies, legislators, consumers and providers have studied and presented solutions to the growing, ineffective and inefficient systems addressing the needs. In the legislative session of 2004, the Aging Department was elevated to Cabinet Secretary level and charged with creating a single, unified department to administer all laws and exercise all functions formerly administered by the following agencies:

...a lot of discussion is taking place in New Mexico to address the Medicaid budget growth around fee-for-service. The Human Service Department realized a diminished growth in Medicaid expenditures following the introduction of managed care for the acute care services. With diminished federal dollars and growing needs within the state, the need to make changes is a priority.

State Agency on Aging (SAoA); Human Services Department (HSD); Department of Health (DOH); and the Children Youth and Families Department (CYFD that relate to aging, adults with disabilities or long term care services. By November 1, 2005, the Aging and Long Term Services Department (ALTSD) Secretary was mandated to provide the Legislative Health and Human Services Subcommittee with a comprehensive plan to provide long term services (LTS) and related services for all populations, including any recommendations for transfer of additional LTS programs from other departments to ALTSD.

From January to October 2005, the ALTSD met with stakeholders from across the state in order to identify areas of progress and challenges, and to develop strategies and policy directions for continued rebalancing towards home and community-based services. In October 2005, at a meeting of the Interim Health and Human Legislative Committee, a report was presented as a synthesis of state legislative directives, input from stakeholders, and evidence-based planning and policy development (i.e. review of other states' promising practices for rebalancing long-term services). That report was the source for most of the information presented in this article. The full report may be accessed by going to http://www.nmaging.state.nm.us/Long_Term_Services_Plan.html.

The report continues to be "tweaked", but essentially the starting point for discussion falls into the categories of Vision for Long-Term Services and Guiding Principles of Long-Term Services.

Vision for Long Term Services:

We envision a long term services system for New Mexicans that:

- Provides more consumer choice and self-direction;
- Provides accessible home and community-based options;
- Offers easy access to choice of culturally responsive, appropriate, and quality long term services; and
- Empowers persons with disabilities, across the lifespan (birth to death), to live independently, productively and with dignity.

Guiding Principles of Long Term Services:

- Ensure dignity and respect of consumers;
- Develop programs and services of highest quality;
- Provide for consumer self-determination;
- Implement state policy by integrating state and federal mandates related to LTC;
- Diversify institutional care options and enhance alternatives; and
- Integrate funding sources to provide affordable services, and
- Concurrent with the rebalancing initiative, the ALTSD continues to pursue a Self-Directed Waiver and Cash and Counseling programs.

Mi Via (My Way) is the self-directed program that is being developed with a planning grant from the Robert Wood Johnson Cash and Counseling initiative. ALTSD in partnership with the Human Services Department and the Department of Health have just submitted a 1915c self-directed waiver application to CMS for approval before implementing this program. Stakeholders continue to work on implementation initiatives.

Additionally, the Human Services Department, as a part of their Salud (Managed Care Contract) renewal process, asked for input on managing long term services. Two companies are currently in negotiation with the department to move dual eligibles into a managed system. Currently, dual eligibles are part of the fee-for-service Medicaid budget. Negotiations have been going on for about a year and, again, stakeholders have been brought to the table to discuss components of managed care for long term care services. The proposed program is called Coordinated Long Term Care (CLTC).

In conclusion, a lot of discussion is taking place in New Mexico to address the Medicaid budget growth around fee-for-service. The Human Service Department realized a diminished growth in Medicaid expenditures following the introduction of managed care for the acute care services. With diminished federal dollars and growing needs within the state, the need to make changes is a priority. Rebalancing from an institutionalized bias to home and community services is seen as one option, but truly more drastic changes will need to be made in order to achieve a stemming of the growth in Medicaid. With numbers climbing in the elderly and disabled, needs for services will continue to increase. Dollars to be spent are on the decline from all sides.

Source of information LONG TERM SERVICES PLAN IN NEW MEXICO: Rebalancing the System November 29, 2005 Submitted by: Deborah A. Armstrong, P.T., J.D., Cabinet Secretary

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Long Term Living Efforts in PA Stalled

By Vicki Hoak

Since coming to office three years ago, Pennsylvania's Governor Ed Rendell and his cabinet members have been committed to rebalancing the long term care system in our state. Pennsylvania spends the fourth largest amount of any other state per capita on long term care because most of the care is being provided in costly nursing homes. Our Medicaid program pays about $15,000 a year to provide in-home services to each of the 21,000 seniors under our waiver program, compared to the $35,000 it spends for each of the 73,000 people residing in nursing homes.

In a 2004 guest editorial in the Philadelphia Inquirer, the Governor's Director of Healthcare Reform, Rosemarie Greco, wrote that Pennsylvania relies too much on nursing homes to care for our elderly. "Our goal is to provide services that help people stay in their homes for as long as possible. That means we need to rethink the way we provide long term care and services. It's a double win. It will save taxpayers millions of dollars and eliminate the barriers that keep people from receiving the long term care and services they need at home."

This shift away from institutional care to home and community-based services isn't new to government. In Pennsylvania, we have supported de-institutionalization for decades, closing several state mental hospitals and mental retardation centers. The U.S. Supreme Court's *Olmstead* decision furthered this cause by ruling that all individuals have a right to be cared for in the least restrictive setting.

Strong Start

One of the first efforts undertaken in Pennsylvania to rebalance our system was to streamline the process to obtain in-home services, which are provided under the Pennsylvania Department of Aging waiver program, known as the PDA waiver. For years, eligibility determination for home and community-based care took up to 3-6 months, quite a different picture from a nursing home admission, which was usually immediate.

Called "Community Choice", this demonstration project administered by local Area Agencies on Aging shortened the financial eligibility application from 24 to four pages, and expedited the clinical assessment so that people could receive in-home services in a matter of 24 hours. It began in the southwest region of the state and has now expanded to ten counties throughout the Commonwealth. The streamlining of the eligibility and the promotion of home and community-based care has been praised by consumers, advocates and providers, which included a special outreach to educate hospital discharge planners, who for years have automatically referred all elderly patients to nursing facilities upon discharge.

To promote in-home services further and in anticipation of reducing admissions to nursing homes, the state's Department of Public Welfare increased the individual resource disregard level from $2,000-$8,000 so that more people would qualify for the program and received federal permission to use an aggregate cap instead of an individual's cap, thus persons with complex needs could receive more services. Telehealth was also reimbursed for individuals with chronic conditions as another cost effective way to keep people out of hospitals and nursing facilities.

Rebalancing efforts were also evident in Pennsylvania's efforts in obtaining several CMS grants including Money Follows the Person, Integrating Long Term Care Supports with Housing and Quality Assurance for home and community-based waivers. These grants are currently in the planning process and our association is represented on many of the workgroups.

The shortage of workers to care for the growing elderly population in the community has also been recognized and addressed in Pennsylvania. The Center for Health Careers Leadership Council was formed to address healthcare workers shortages including nursing and direct care workers. PHA's Executive Director has been appointed to the council, which is charged with making recommendations to address both professions. Pennsylvania has also received one of five Better Jobs Better Care grants from the Robert Wood Johnson Foundation to develop a core curriculum for direct care workers in the long term care system and improve the work environment for frontline workers.

With this amount of activity focused on keeping people in their homes, it was no surprise when PDA waiver consumers increased substantially from 12,071 in 2003 to 20,569 in 2006, with no correlating reduction in nursing home admissions. As a result, several of the initiatives discussed

above have been stopped in their tracks. The statewide expansion of the Community Choice program and telehealth reimbursement have stopped and the PDA waiver program is undergoing substantial review and redesign.

In addition, the Governor's office has created a new council, the Long Term Living Council, to examine the condition of long-term care in Pennsylvania, and to provide recommendations and guidance to the administration how to best address the long term care needs of Pennsylvanians. The council is composed of cabinet members from the departments of Aging, Welfare and the Governor's Budget, Healthcare Reform and Policy offices.

While we remain optimistic and recognize that change doesn't happen overnight, unfortunately the state's proposed budget for next year does little to fuel our optimism. There is no increase for homecare providers, yet nursing homes are slated to receive a 4 percent hike. There are funds to serve 2,800 more seniors under the waiver program and a nursing home transition demonstration, yet there is an initiative to begin selective contracting for homecare providers – decreasing the number of in-home providers. The waiver program, once promoted extensively, now has stricter controls over who is served and a Medicare Audit of home care agencies providing waiver services is about to begin.

Discouraging signs – yes, but members of the Pennsylvania Homecare Association are committed to continuing our advocacy efforts to ensure that our state develops a long term "living" system that provides care and support when and where consumers want it – at home.

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Medicaid: Thumbs Up, or Thumbs Down

By Peter Cobb

Vermont Medicaid got thumbs up recently from the federal government to run two first-in-the-nation's Medicaid waiver programs that the state hopes will end the nearly 10-year slide into red ink and possibly save the program from financial ruin. The first, a global commitment budget transforms Vermont Medicaid into a managed care program and the second, the 1115 home and community-based waiver, puts home care on an equal footing with nursing homes.

Vermont Medicaid, like Medicaid in many states, is in serious financial trouble. Costs have grown dramatically in recent years averaging 12 percent increase each year for the past decade, a rate not sustainable for the next decade. The state hopes the two new waivers will help get the budget under control and also guarantee needed services.

Vermont Medicaid covers 145,000 people, 25 percent of the population. Thirty-four percent of the state's children (54,000) are on Medicaid. Children qualify at 300 percent of poverty and adults at 185 percent of poverty. Few states have enrollment benefits this generous.

Under the global commitment budget, Vermont Medicaid is a public Managed Care Organization (MCO). The state gets a lump sum payment each month from the federal government to manage all Medicaid programs except the home based waiver program.

Vermont Medicaid is operating under a 5-year budget ceiling set by the federal government. The ceiling is based on FY04 expenditures and includes a 9 percent increase each year. State planners say the lump sum payment gives them the ability to carefully manage the program, something they have been unable to do in recent years. The waiver also gives the state more flexibility in the way it uses its Medicaid resources. Vermont is no longer bound by the traditional Medicaid rules. Under this new agreement, the state can fund programs previously not covered such as preventive medicine and chronic care initiatives. State planners are so confident that the spending for the next 5-year period will be below the 5-year ceiling that they expect to use the unspent money to expand some of the preventive programs. They also suggest that expansion of these programs will result in savings five or six years downs the road that can be used to expand and add more preventive programs.

State planners also say that the global commitment budget encourages inter-department collaboration and consistency across programs because the various departments with Medicaid programs now must work closer together to assure that spending stays below the cap.

Critics say state planners are living in fantasy land. If the worst happens and the recent 10-year history is repeated with more people needing more services, thousands of Vermonters will be left with no or limited services because the state gets only the agreed on lump sum payment. They also say that the state is using curious math in projecting savings from programs such as the chronic care initiative (across-discipline management of chronic diseases such as diabetes), which haven't yet saved a dime and probably won't save enough to make a difference.

The 1115 home and community-based waiver started last October. The key to this program is that home care services are now entitled services on equal footing with nursing home care. Before October, the state had 1100 "waiver slots" available. When these were filled, patients got placed on a waiting list. There is no waiting list now. If a patient wants home care rather than nursing home and is eligible, he is entitled to get what he/she wants.

Like the global commitment budget, the home and community-based waiver was written because the state must get a handle on spending. There are approximately 80,000 Vermonters 65 years old or older, nearly 13 percent of the population. That number is expected to increase to 92,000 by 2010, a 15 percent increase in just seven years. To deal with the projected increase in demand, Vermont sought and got the 1115 Medicaid Demonstration Home and Community-based waiver which make home care service an entitled service similar to nursing home care.

The waiver provides case management, personal care, respite care, adult day care, companion services, personal emergency response, assistive devices, enhanced residential care and assisted living services, homemaker and home modification. Under the new plan, patients are divided into three groups, highest need, those needing nursing home level services (including waiver services); high need, those not yet needing nursing home level care but in danger; and moderate need, those needing essential household support services such as homemaker.

Under the new eligibility rules some people who would have qualified for nursing home services are no longer eligible because the eligibility requirements are stricter under the new waiver. Only highest need patients get nursing home service. This is the most controversial section of the waiver and the most worrisome to the nursing homes. The program is only five months old, too early to gage the impact on the nursing home industry. It is also too early to gage the impact on home care age agencies. Eligible patients can either use a home care agency or hire their own staff. Past experience has about half choosing the agency model and half personal directed care. Whether that ratio changes or not, is not yet known.

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